

## COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES Service Authorization (SA) Form

## **Continuous Glucose Monitors**

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION			
Last Name:	First Name:		
Medicaid ID Number:	Date of Birth:		
PRESCRIBER INFORMATION			
Last Name:	First Name:		
NPI Number:			
Phone Number:	Fax Number:		
CONTINUOUS GLUCOSE MONITOR (		_	
CGM Product (Please include all pieces	s needed for use):		
Frequency of sensor use:			
Length of Therapy:			
(Form continued on next page.)			

Virginia DMAS SA Form: Continuous Glucose Monitors					
Me	ember's Last Name: Member's First Name:				
DI	DIAGNOSIS AND MEDICAL INFORMATION				
Fo	For an initial request, complete the following questions to receive a 12-month approval:				
1.	Is the member at least 2 years of age? <b>AND</b>				
	☐ Yes ☐ No				
2.	Has the member been diagnosed with diabetes by their primary care physician, or another licensed health care practitioner authorized to make such a diagnosis? <b>AND</b>				
	☐ Yes ☐ No				
3.	Is the member being treated with insulin and/or does the member have a history of problematic hypoglycemia? <b>AND</b>				
	☐ Yes ☐ No				
4.	Has the member's treating practitioner concluded that the member (or member's caregiver) has had sufficient training using the continuous glucose monitor prescribed as evidenced by providing a prescription? <b>AND</b>				
	☐ Yes ☐ No				
5.	Has the continuous glucose monitor been prescribed in accordance with the Food and Drug Administration				

(Form continued on next page.)

☐ No

indications for use?

Yes

Virginia DMAS SA Form: Continuous Glucose Monitors

Member's Last Name:	Member's First Name:

For a renewal request, complete the following questions to receive a 12-month approval:			
<ol> <li>Does the member continue to meet the relevant criteria ide</li> <li>Yes</li> <li>No</li> </ol>	entified in the initial criteria? AND		
<ul> <li>Is the member being monitored for benefit of using the conevery 6 months in the first 18 months of use or annually aft</li> <li>Yes</li> <li>No</li> </ul>			
Prescriber Signature (Required)	Date		

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process. Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826

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